DOCUMENT RESUME

ED 235 616 EC 160 468

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TITLE Special Needs in Education (E241): The Professionals, Unit 7.
INSTITUTION Open Univ., Walton, Bletchley, Bucks (England).
REPORT NO ISBN-0-335-13124-7
PUB DATE 82
NOTE 43p.; For other course components, see EC 160 461-477.
AVAILABLE FROM Open University Educational Enterprises, Ltd., 12 Cofferidge Close, Stony Stratford, Milton Keynes, MK11 1BY England (no price quoted).
PUB TYPE Guides - Classroom Use - Materials (For Learner) (051)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Ancillary School Services; Course Content; *Disabilities; Elementary Secondary Education; Interdisciplinary Approach; Professional Education; Professional Occupations; *Professional Personnel; Professional Training; Psychologists; Social Workers; Special Education Teachers; Teachers; Teamwork; Therapists
IDENTIFIERS United Kingdom

ABSTRACT

The sixth of 16 booklets designed for use in an Open University course on special education for handicapped students in the United Kingdom, this document features information on the professional groups involved with special education (psychological, paramedical and therapeutic, educational, social, medical, nursing, and legal). Specific roles of educators, health professionals, therapists, social workers and psychologists are delineated for the clinical, community, and residential settings. Teamwork as part of a multidisciplinary approach is discussed, as are issues in client-professional relationships (including confidentiality and accountability) and the relative status of certain professions. The history of the growth of the educational, psychological, social work, health and welfare professions in the United Kingdom is followed by implications for professional training. The potential for overprofessionalization and suggestions for four new types of professionals (peripatetic specialists; advisory support services workers; community based care workers; and laypeople, including parents) is examined. (CL)

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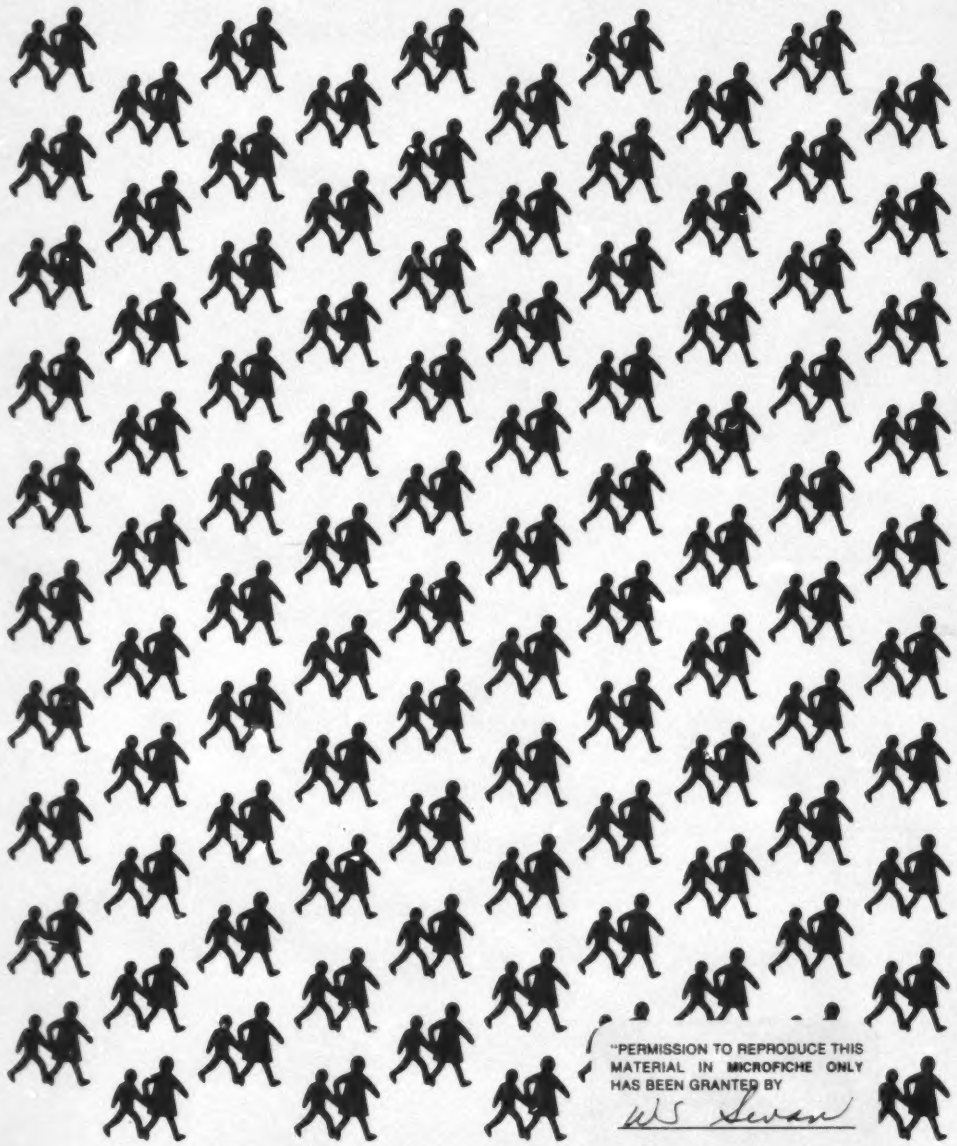
The Open University
Educational Studies: A Second Level Course
Special Needs in Education

THE PROFESSIONALS



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The Open University
Educational Studies: A Second Level Course
E241 Special Needs in Education

Unit 7
The professionals

Prepared by Patricia Potts for the Course Team

The Open University Press

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The Open University Press, Walton Hall, Milton Keynes MK7 6AA
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Designed by the Graphic Design Group of the Open University.
Printed in Great Britain by Albert Gutt Ltd, Grimsby, England
ISBN 0 335 13124 7
1.1

Contents

	Note on reading	4
	Broadcasts	4
1	**Introduction**	5
2	**Working together—who does what**	7
	Case study: Michael	7
	Solos	9
	Teamwork	12
	A clinic setting	12
	A community setting	13
	A residential setting	14
	Professional power: assessment and identification	16
	Professional networks: status	17
	Client–professional relationships	19
	Confidentiality and accountability	22
	Summary	22
3	**The growth of professions**	23
	Historical background	23
	Perspectives on special education	29
	Generic or specialized training?	31
	Training and work	32
	Overprofessionalization	34
4	**New professionals for old**	35
5	**Conclusion**	37
	References	39
	Acknowledgements	40

Note on reading

Set reading

The readings for this unit are to be found in:

SWANN, W. (ed.) (1981) *The Practice of Special Education*, Oxford, Basil Blackwell/The Open University Press (the Reader). They are:

DHSS/DES (1976) 'The provision of health services to handicapped children and their families (The Court Report)' (Reading 4.4).

TOMLINSON, S. (1981) 'Professionals and ESN(M) education' (Reading 4.3).

The case study for this unit is to be found in:

BOOTH, A. J. and STATHAM, J. (1982) *The Nature of Special Education: people, places and change*, London, Croom Helm/The Open University Press. It is:

'Off duty: educational psychologists discuss their job' (Case study 26).

Further reading

If you wish to read more on subjects discussed in this unit, I recommend the following:

FITZHERBERT, K. (1977) *Childcare Services and the Teacher*, London, Temple Smith.

ILLICH, I. *et al.* (1977) *Disabling Professions*, London, Marion Boyars.

OSWIN, M. (1978) *Holes in the Welfare Net*, London, Bedford Square Press.

PUGH, G. and RUSSELL, P. (1977) *Shared Care*, London, National Children's Bureau.

TAYLOR, L. *et al.* (1980) *In Whose Best Interests?*, London, The Cobden Trust/MIND.

TIZARD, J. (1973) 'Maladjusted children and the child guidance service' (and seven replies), *London Educational Review*, **2** (2), pp. 22–60.

Broadcasts

TV programme 4 and Radio programme 3 are linked to this unit. Further details are given in the associated broadcast notes.

1 Introduction

> I'm a professional. I don't do it just for the love of the thing, I'm very good at it. I take it seriously and work hard. And I need the money.

1.1 Professionals *should* discipline themselves to develop talents or skills to a high level of personal satisfaction, financial independence and public approval. Particular professions may not guarantee high status and fat rewards for their graduates, but nearly all professions have an image of competence and authority. But we, as laypeople, are supposed to lack knowledge and skill, and our status is low, although we are the consumers of professional services.

1.2 There is, however, a growing number of professionals whose tactics are quite different: they aim for close communication with their clients on equal terms, they frequently earn public disapproval and they offer long-term help with problems that often cannot be solved. These are workers in the health, education and social services, professionals whose brief is to care. But are they like amateurs, then, working for the love of it, giving a continuing support to clients whose views they champion, not looking for self-satisfaction or a larger mortgage? Is it possible for a 'caring professional' to be both caring and professional at once? Caring for clients may lead you to question your assumed professional role; professional commitment may involve climbing an academic and administrative ladder up and away from your clients.

1.3 More than 30 professions are involved with children referred for special education, although the extent of their commitment varies. Table 1 presents a rough grouping of professionals according to how much of their work is with children with educational handicaps. These professionals form an expanding, largely separate sector of the education system and are significant characters in the lives of children who have problems in school.

Table 1 Professional involvement in special education.

Professional group	Extent of commitment		
	Continuous	Frequent	Occasional
Psychological	educational psychologist; clinical psychologist; child psychotherapist		
Paramedical and therapeutic	speech therapist; music therapist; art therapist	occupational therapist; physiotherapist	
Educational	teacher in special education; special education inspector; special education advisory teacher; home tutor	school counsellor	teacher in ordinary school; careers officer; further education lecturer
Social	psychiatric social worker; special social worker (e.g. for the deaf); residential care worker	youth worker; education welfare officer	social services department worker; probation officer; housing officer
Medical	child psychiatrist	school medical officer; specialist doctor	paediatrician; general practitioner
Nursing	special health visitor for the handicapped	health visitor	children's nurse
Legal		Juvenile Bureau police officer	

1.4 The three main questions I discuss in this unit are, first, what are the professionals trying to do and can they do it? Do they do any good? Do they do any harm? Second, how did the present system evolve: does a historical perspective on the growth of the professions and their training procedures help to make sense of what they do now? Third, how can the professionals become more flexible and responsive to changing needs?

1.5 Mental, physical and sensory disabilities, together with economic and ethnic disadvantages, are major causes of handicap, and children with each of these difficulties are found in the special education system. What can a caring professional do to prevent, help with or reverse either the disability itself or our frequently negative responses? Most professionals involved in special education are usually particularly concerned either with prevention or remediation. Some success can be achieved, for example in reducing the incidence of genetic disease, relieving stress or correcting defective vision or hearing, but most of the time professionals actually perform a role that combines short-term welfare work with social control, often called 'holding' or 'containing' the situation.

1.6 The causes of many congenital defects are unknown and irreversible, the number of children with problems that take them to the juvenile courts or psychiatric clinic is rising, provision for children classified as ESN(M) and maladjusted has mushroomed. So, more professionals are recruited for the increasing numbers of children they have identified as having special needs, as if the failure to do their job in terms of problem-solving justifies their proliferation. It sounds like policing. But it also shows that, while the professionals in special education have considerable powers to influence the lives of their clients, the options over which they have control are not, perhaps, those which would make a fundamental difference to disadvantaged children. And if professionals *were* in a position to improve the disabling social, economic or personal lot of their present clients, what implications would this have for their own continuing careers?

1.7 This course asks whether it is possible for children with special educational needs to participate more in the ordinary education system. A widespread commitment to integration, in practice as well as in theory, would mean a radical change in the traditional values of our decentralized and diverse system, and would have a profound effect on the professionals.

1.8 Professionals spend a lot of time defining clients' needs and detecting incipient problems. Identifying children as having special educational needs is a prelude to placing them where these needs can be met, and thus depends for its validity as a professional practice in the present system upon a range of alternatives to the ordinary classroom. Educational psychologists (EPs) and child psychiatrists, for example, are particularly involved with assessment and referral, with choosing the routes children will take through the system. Special education teachers, child psychotherapists and residential care workers, on the other hand, are predominantly concerned with teaching, therapy, treatment, care—whatever kind of continuing professional relationship is offered after referral. And these relationships become closely associated with the different institutions in which they develop. The jobs done by many professionals thus depend upon the dual system. The more a job involves decisions about moving children between the two parts of the system, or carrying out a plan of action in tailor-made seclusion, the more the duality justifies the job, and the less easy it would be to accept integration.

1.9 Segregation does not just mean separation, however, it usually means compulsory separation. Integration would reduce the placement options over which the main referring professionals preside, and parents and children would no longer need to try and resist unacceptable referrals.

1.10 Of these professionals who are continuously involved with special education, some are employed by the education authorities, some by the health authorities and some by the social services departments. Separate special provisions for certain groups of children have confirmed independent training–employer–workplace routes, which would be eroded by the process of integration.

1.11 If a policy of integration were implemented, significant features of the present system would disappear: initial referral, transfer, formal assessment, the persuading of unwilling parents. Which professionals would this affect most? Those who are most

concerned with assessment and referral—the psychologists, psychiatrists, school doctors, head teachers. The planning of services by local authorities would also be transformed, affecting the work of inspectorates and advisory staff, who have often made their mark in the past by proliferating segregated provisions.

1.12 If ordinary schools offer a continuum of provision in one place, they will become the working base for a wider range of professionals than at present, especially for peripatetic specialists, advisors and support staff. Relations with children, teachers, other professionals, families and local communities would also be substantially changed, as the responsibility for making educational decisions would be shifted in favour of those close to, rather than remote from, the children concerned. In this way the issue of integration is bound up with that of reprofessionalization, or deprofessionalization (see Section 4), and both are bound up with that of the establishment of non-selective, comprehensive schools.

1.13 Unit 8, *The powers that be*, relates the world of the professionals to that of the civil servants and politicians, the policy-makers and planners. Unit 9, *Origins*, looks at the historical roots of the present system of special education, at why and how certain professions gained ground at the time they did, and Unit 10, *National perspectives*, looks at the work of professionals in the US, Scandinavia and Italy, and how innovative policies have been implemented. Unit 3, *Family views*, discusses the work of the professionals from the families' perspective, both as dependent clients, as consumers of services, as pressure-groups in education and as 'professionals' themselves. Unit 3 therefore adds a vital dimension to the themes of this unit.

1.14 In Section 2, 'Working together', I look at what the professionals do, both as individual specialists and as multi-disciplinary teams, at their status relative to each other and to clients, and at the question of professional accountability. Section 3, 'The growth of professions', looks at their historical development and training arrangements to try and understand their current interests, the maintenance of their professional identities and the extent of their commitment to the present system. Section 4, 'New professionals for old', looks at examples of changing professional roles and at the constraints on change.

1.15 Physiotherapy as part of an integrated paediatric service is the subject of TV programme 4. Case conferences, an almost daily feature of the work of many professionals, are the subject of Radio programme 3.

2 *Working together—who does what*

Case study: Michael

2.1 To illustrate how a variety of professionals can enter the life of a child, here is the story of one boy:

> Michael's mother was 14 when he was born and he thought she was his sister until he was about eight. The enlightenment was a profound shock and it was at this time that his primary school first referred Michael to the nearby child guidance clinic, housed in the community health centre where he already came regularly to see the optician. In November 1973, the EP tested Michael and gave him an IQ of 96, recommending that a remedial class or a tutorial class might help with his reading and his social relationships, and concluding that, although immature, his potential was high. In May 1974, a teacher was appointed to the clinic and Michael began twice-weekly sessions there.
>
> A psychiatric social worker (although not always the same one) was in touch with Michael's family and soon discovered that special school was used as a threat to get him to behave and that, even after candid and amicable discussions, there was no consistency between Michael's handling at home, at school and at the clinic. In January 1975 a case conference was held to discuss Michael's chaotic family situation. Sometimes his granny's new and comfortable flat

would be full to bursting with relations, and at other times there would just be the two of them, particularly after the death of the grandfather. Michael's mother was to marry again and move to another flat; he could remain with his granny or go and live with his mother for the first time. He decided to go, but when his unemployed step-father wanted to return to Turkey, he returned to granny. About a year later, his mother returned to have a second child. In February 1975, Michael was seen by a psychiatrist at the clinic.

In May, aged ten, he was circumcised. Michael had had a rectal deformity at birth, now corrected, but all this tended to focus his attention on unspeakable bodily functions. In November, the psychiatric social worker referred Michael to a private clinic some distance away because it was felt that he needed regular therapy to cope with his bewildering life and what appeared to be incipient sexual problems, and it was not then available at the child guidance clinic. His experience, however, turned out to be far from therapeutic as his first therapist resigned and the second one died.

In April 1976, a conference at this clinic decided that there was little of value they could offer and the local authority clinic filled in the special education referral forms. Michael's views were mixed: 'I might learn better in special school'; 'I won't live to go to boarding school. My granny said I was mad'. In July the private clinic's EP tested Michael, gave him an IQ of 118 and wished him well in his secondary school.

Michael transferred to secondary school in September 1976; the clinic teacher thought it was important for him to have the opportunity to be like everyone else, particularly as he saw special school as punishment.

She was away on study leave between February and June 1977, and this was a turbulent time; the clinic and the school held a case conference in April after which the school referred Michael back to the clinic, urging special school, both for educational and social reasons. In May Michael was in trouble with the police for breaking and entering and again, in July, for shoplifting. He was put on a Saturday attendance order and had to travel some way with a social worker to a rigorous gym session. He was truanting from school now, and was frequently visited by the Education Welfare Officer (EWO).

In June Michael was again tested by an EP, given his original IQ score of 96 and, although a boarding school was preferred, a day maladjusted school was recommended, which the family would be more likely to accept. The trouble with the police, however, raised the question of adequate control, which a day special school would be concerned about, arguing that little can be achieved when there is no stability at home. During the summer holidays, plans were made for Michael to go into a children's home. His granny wavered between relief and shame, although his mother agreed to the idea. But the staff at the home were reluctant to take on what had been presented as a boy of unlimited, unpredictable deviance. Finally, it was arranged that the granny, who certainly needed the money, should be paid as a foster-parent and undertake to keep a firm hand on Michael. Michael was very upset to learn that his granny had to be paid to keep him on.

In October the head of the local day maladjusted school refused to accept Michael, on the grounds of lack of suitable staff and of support at home, although it is quite likely that she, too, felt that such a dare-devil would not fit into what she hoped was a family group.

After several months out of school altogether, Michael was accepted by another day maladjusted school, further away of course, but he seemed to settle in quite well. He continued to see the clinic teacher, but less often, until she left in July 1978, and the psychiatric social worker kept in touch with his granny until the case was closed early in 1979, when Michael was 14.

In six years, four schools, two clinics and members of eight different professions had been actively involved in Michael's life. He wondered if anyone really wanted to look after him. Professional interventions were often contradictory, tardy and repetitive, but Michael was able to make some good relationships with those he knew for several years and will have been at the special school, regularly attending, for three and a half years when he leaves in the summer of 1981.

Activity 1 Write down your responses to the following questions about Michael's story:

(a) What were his problems at home and at school?

(b) What were their causes?

(c) What did Michael want and what did the professionals try to do? Why were these not always the same?

(d) Why did he cause such panic in the professionals?

(e) How does Michael's story illustrate an escalation of professionals involved in one case?

(f) Why was Michael tested by an EP three times? What did it achieve for him, for the schools, for his family, for the professionals?

As you read through the unit, see how these issues are taken up. Section 5 suggests how the needs of both client and professional could be satisfied.

Solos

2.2 The next few paragraphs give brief descriptions of the work of three professionals: an EP, concerned with placing children in special education; a health visitor, whose initial referral may alter the course of a child's later educational career; and a speech therapist, whose involvement cuts across institutional and administrative barriers. (But bear in mind that no two members of one profession do the same job.)

2.3 An EP is employed by the LEA and can be based at the authority's main offices, a child guidance clinic or a schools psychological service office in the area. EPs can be involved with children placed in all categories of handicap and can be consulted throughout a child's educational career. An EP commonly has a local 'beat', consisting of primary and secondary schools, but may also have responsibility for a group of special schools and units. EPs are usually involved in running local in-service teacher-training. A host of organizational, social, curricular, behavioural, emotional and learning problems may be referred to the EP for advice and help, and most of his or her consultations and placement decisions are still rubber-stamped by intelligence-testing. Thus EPs often rush about seeing children for a one-off interview, then bury themselves under a pile of the resulting paperwork. Some EPs have very little direct contact with special schools, and many concentrate on children in primary or secondary schools. But any referral for special education requires an assessment and diagnostic report from the EP, who may also have the task of persuading reluctant parents. EPs vary the amount of time they spend with teachers in schools, with LEA officers, with the inter-disciplinary team at a child guidance clinic, with other psychologists, with health or social services workers or with the children and their families.

2.4 Health visitors can be based in an area health authority clinic, a group general practice, a health centre, a hospital or with a district handicap team. Their domiciliary visiting is the most important part of the job, giving general or preventive nursing

Health visitors working with the Hester Adrian Centre infant project in Manchester help parents to teach their babies at home.

and child care advice and detecting problems as they emerge. Health visitors are notified of all births in their area, and visit at ten days, when the midwife transfers responsibility. Health visitors are more accessible than many professionals, running regular walk-in child welfare clinics and encouraging people to get in touch whenever they want. Their knowledge of families and local communities can be invaluable and is gradually being appreciated by traditionally more prestigious, but remote, professions. The establishment of special health visitors for the handicapped is a recognition of the importance of their initial contacts.

2.5 Speech therapists are employed by the health authorities and are based either in a hospital or a community health centre, or both. They see children (and adults) individually or in groups and, although they do not automatically visit special schools, many have regular sessions in ESN(S) or physically handicapped special schools or special units and classes for language-disordered children. Speech therapists do not enjoy the same high status and rewards as EPs, but this is changing as greater attention is paid to the educational significance of problems of communication. Speech therapists are concerned with problems of fluency and articulation, which may involve overcoming some physical defect, as well as problems connected with the symbolic processes involved in comprehending and producing language. Like EPs, speech therapists employ a range of formal assessment and informal therapeutic techniques and can be overwhelmed by referrals. This means long waiting-lists, the limbo of periodic reviews, or uselessly infrequent appointments. Speech therapists also suffer more than EPs and health visitors from a labyrinthine administrative situation, involving hospital, area health authority and LEA.

2.6 A speech therapist summarizes in Table 2 the differences she sees between her job and that of the special school or language-unit teachers, with whom she most frequently has to work. The differences are enormous. Do they reflect an appropriate division of professional labour, or an unnecessary preservation of separate professional interests? Do they coincide with your own experience? Or has there been some osmosis? What comes through clearly from the table is a traditional view of the teacher as being primarily concerned with ordinary children, and the therapist as being concerned with the special children, and of this being unsatisfactory. The opportunities for multi-professional collaboration have existed for a long time, however, and working together is a current refrain among professionals.

Table 2 Job comparison.

Teacher	Therapist
Works with a group	Mainly works with individuals
Is oriented to task completion	Is oriented to discovering obstacle(s) to task completion
Sees resolution of problems as taking place within school	Sees resolution as being brought about by a group of workers
Has obligation to achieve results	No results necessary—no pressure
Working situation does not require communication with other workers	Communication essential due to professional isolation
Generally does not have time for, or does not regard as truly significant, observing children	Observation is the basic tool and skill of a speech therapist
Has formal relationship with parents	Has informal relationships with relatives
Mostly notes achievement	Always notes non-achievement

Working in the gym with a physiotherapist and a helper.

An audiologist testing a hearing-impaired child.

Child psychologists visit young children at home to assess their abilities.

Reading Now read the extracts from The Court Report (1976) (Reading 4.4). How critical is Court of the present arrangements?

Comment Court outlines a scheme for integrated child health services and advocates the involvement of parents and joint in-service training of professional staff, breaking down traditional barriers where new roles and skills are required. A number of forward-looking changes are recommended but, as perhaps you noticed, the tone of the criticisms of the present arrangements is muted. So far, few of these recommendations have been implemented.

2.7 Have you any experience of multi-professional teamwork, as a client, professional or family member? Here is the Court Report's argument in favour of this approach:

> the real cause of educational failure may lie in the individual's psyche or physical health or in the environment of home, school or society. To disentangle the strands is beyond any single expertise. Medical, social and psychological advice have therefore to be available if the child is to receive the best education that can be offered, and a full team approach with the teacher will sometimes be essential.
>
> (Reading 4.4)

2.8 Working together in a multi-professional team can be democratic, enlightening, stimulating, supportive, flexible. But it can also be time-wasting, expensive, threatening, bureaucratic and confusing. Such a team could represent a last-ditch stand to preserve separate professional identity, or it could facilitate the communication and transferring of knowledge and skills as demand arose. Multi-disciplinary teams are to be found in child guidance clinics, the few district handicap teams set up as a result of the Court Report (1976), residential provisions, area paediatric services and numerous *ad hoc* assessment groups.

A clinic setting

2.9 Since the publication of the joint DES/DHSS Circular 3/74 Child Guidance, the child guidance clinics, whose clients are children with a wide range of emotional and behaviour problems, have been trying to sort out the problem of multi-disciplinary teams (see also 'Historical background' in Section 3). Most clinic teams include the following professionals, but their number and theoretical background vary considerably: *child psychologists*, usually in the clinic on a part-time sessional basis, on loan from a teaching or specialist hospital; *psychiatric social workers*, employed by the LEA medical departments, full-time in the clinic or half-time in a special school for 'maladjusted' children; *child psychotherapists*, usually part-time, working in a range of LEA and private clinics; *EPs*, based at the clinic, but out in schools, LEA offices or with peripatetic remedial teachers a good deal of the time (although a few clinics are run by psychologists); *remedial teachers*, in the LEA child guidance clinics full-time but not always with a permanent classroom; *clinical psychologists*, usually part-time, employed by the health authority and in the clinic as part of the therapist quota, often to work with schools and their problems of behaviour management. Traditionally, the *consultant child psychiatrist* is the leader of the team, because he or she is in a position to accept medical responsibility. The senior psychiatric social worker often acts as second-in-command, and as acting leader when the consultant psychiatrist is not in the clinic—which is a good part of the week. London-based psychiatric social workers can take advantage of the courses available at the Tavistock Clinic, the Child Guidance Training Centre or the London School of Economics, for example, to train part-time as a psychotherapist. It is not uncommon for therapists to have a private practice, supervision for their own work and personal analysis at the same time as their clinic caseload. Child psychiatrists have not usually studied much social psychology or sociology, and the *remedial teacher* may not have any relevant training, but would often be encouraged to enrol for an in-service course.

2.10 Once or twice a week, most clinics have an hour or so together as a team, to discuss difficult cases, future policy, journal papers or the latest referrals. (In some clinics, however, this is still done by a triumvirate of psychiatrist, psychiatric social worker and EP who distribute the cases among the team as appropriately as they can.) These are internal group meetings and frequently involve serious decision-making. Hierarchies emerge, particularly with regard to the relationship between psychiatrist and psychiatric social worker—a classic male/female, highly-paid/inadequately-paid, part-time/full-time tension. Even when individual psychiatrists are only too willing to vacate their throne, acknowledging that when it comes to school-based work they are the initiates, administrators at the LEA offices, for example, perpetuate the imbalance. Psychologists, by their frequent absence from the clinic, and psychotherapists, by the secrecy that frequently surrounds their work, can remain outside the hierarchy, but sometimes to their colleagues' and their own dissatisfaction.

2.11 In 1974, school health services were transferred from the LEAs to the area health authorities, and this had implications for the clinics because they had been under the principal school medical officers since 1959. Also, ways of working varied from 'detailed psychological, social and psychiatric investigation and . . . prolonged and intensive treatment for selected cases' to more general consultative work. Circular 3/74 advocated a 'network of services' to replace the 'self-contained, highly specialized' clinics, and quoted as examples the school psychological services, child psychiatric services, social services and child health services. Many clinics felt that they already provided such a network, especially those whose members were doing a lot of work in local schools. But discussions followed on referral, responsibility for cases, reporting back to referring agencies and record-keeping. The outcome in London was an ILEA Medical Department document of 1979, *Relationships and Leadership in Child Guidance Units*, which attempted to spread professional responsibility and to separate this from an administrative, co-ordinating role within the clinic and with the LEA officers. In practice, the consultant psychiatrist is often the co-ordinator, and the senior psychiatric social worker still has a good deal of extra administration. These issues were the focus of the 1980 inter-clinic conference: why do EPs detach themselves from their clinics? How willing are child psychiatrists to move away from an institutional setting? How can psychiatric social workers be expected to combine the skills necessary for child guidance and social services department work? Could child psychotherapists communicate more about their work, enabling both the team and parents to become involved, trusted and informed? Workshop discussions demonstrated how difficult it is for professionals to air their grievances in a multi-disciplinary team, even when it is composed of people used to examining their own motives, and it was felt by the organizer that concrete inequalities—pay, for example—were not touched on.

A community setting

2.12 Child guidance clinics have been in existence since the 1920s. District handicap teams (DHTs), on the other hand, were not established until 1978, following the recommendation of the Court Report for an 'integrated child health service'. A DHT was to be based at a district general hospital child development centre. Recommended membership included a *consultant community paediatrician*, a *nursing officer* with experience of handicapped children or a *child health visitor* with a special interest in the handicapped, a *special social worker*, a *psychologist* and a *teacher* (for example, a peripatetic teacher of pre-school children). A collaborating team of nursing officer, child health visitor and general practitioner paediatrician would offer 'primary care' to handicapped children. University teaching hospitals would serve as regional centres for severely and multiply handicapped children. But very few DHTs have been set up outside the London area.

2.13 The DHT diagnoses, assesses and treats handicapped children in an attempt to detect problems at an early stage. It also tries to support parents and families and run training seminars for other professionals—'a single district supporting service functioning both inside and outside hospital' (Reading 4.4). The Court Report also advocated a single child psychiatric service, a 'network' including LEA child guidance clinics and hospital child psychiatric units. (See Section 3 for an account of why these two services are separate.) One of the main hopes was to involve consultant paediatricians in more community-based work, making them more accessible.

2.14 How does the blueprint work in practice? There are many variations, and I shall just describe here one DHT. It has no paediatricians, but three senior medical officers and one principal medical officer, one health visitor, a speech therapist, a special social worker for the under-fives and an EP. They are all women. It is based in a community health centre but has close links with the prestigious teaching hospital whose area it serves. The team has a full meeting one morning a fortnight (much less often than a child guidance clinic team) and a typical agenda might include: policy-making, deaths of children, matters arising and a discussion of about ten children, both new and continuing cases. This particular team is as concerned with management and policy as it is with assessment, taking the view that assessment should be carried out at a special assessment centre. A new assessment centre is to be opened, and its teacher will join the DHT. Also, the principal medical officer is a member of the hospital planning team responsible for child health care in that district.

2.15 All the medical officers involved in this DHT are responsible for community well-baby clinics and the handicap register, and they focus on long-term developmental problems, looking after out-patients rather than acute cases. It was established in January 1978 and many of the potential difficulties with conflicts of role do not arise because the team members like each other. But there are problems: a range of professionals is licensed to descend on one family, which is harrassing, confusing and wasteful. If the family know you, like you, trust you, understand you and what you are trying to do, then does it matter who you are? Why have a team instead of a one-man band? Children often attend different hospitals for different complaints and even when the hospitals communicate, this does not necessarily eliminate duplication of work. And it is sometimes felt that other professionals expect too much of the DHT members.

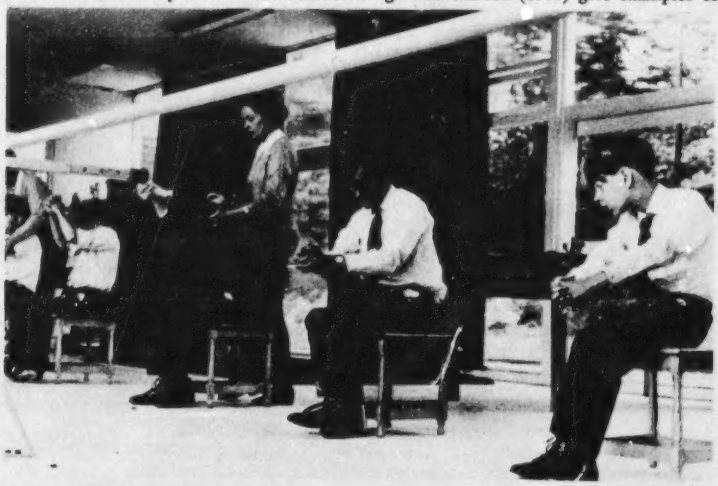
2.16 Health visitors are clinically responsible to senior medical officers for what they do, but administratively responsible to the senior nursing officers who control their conditions of service. The health districts are supposed to monitor the work of the DHTs, but the problems of evaluation are similar to those of the child guidance clinics. In practice very little evaluative work is undertaken; team members have very little time, and would probably find it very difficult to define their aims in such a way as to make the results of such a study informative. And, if it was discovered that the DHT was not achieving its aims for most of the clients, then it is doubtful that it would have the muscle to press for change outside. Clinic and community teams thus tend to be conservative, endeavouring to help individuals rather than change a system which offers help in a way that many clients see as stigmatizing patronage. David Ingleby (1974) argues that this does not merely represent liberal weariness but a paternalistic contradiction: '. . . the "people professions" operate with a variety of paternalism that is quite incompatible with their claim to be "helping people to lead better lives" '. This is because professionals cannot really afford the clients' rocking of their boat. The DHT I have been describing operates in an area where parents are vocal and often organized into quite powerful pressure groups, and it encourages them, as well as other professionals, to regard the team's office as an open house. But if a doctor believes that teaching is inappropriate for handicapped under-fives, that such work is the province of the health visitor, and therefore makes no referrals, the fragility of the team structure is at once exposed. This can also happen because the team includes members whose jobs are new and have no established guidelines, for the potential freedom can also mean vulnerability and powerlessness. One special health visitor felt that she needed more support from members of her own profession.

A residential setting

2.17 In a residential setting professional roles are further complicated by the need to include mothering and fathering. In one residential special school for 'maladjusted' children, the care staff did not live in, because it was thought that they needed the break from such a demanding job. But some of the teachers did live in, because they felt that they needed to strengthen their relationships with the children. So it was the teachers who played the parenting role, but the care staff did not take over the pedagogic role. What a confusion! In some residential schools, the seeming impossibility of working out clear professional boundaries that make any sense—either to the staff or to the

pupils—and the chronic shortage of all kinds of resources have meant that care workers have taught and teachers have cleared up and made the tea. Co-operation in practice depends upon harmonious personal relationships which are not reflected in the relative status of the professions involved. The teacher who makes tea will be paid more than the care staff who help with reading. Teachers '[are] the most important child-carers in residential schools . . . special boarding schools [are] by definition treatment centres and work in class [is] only of true value when supported by constant application outside' (NUT, quoted by Shearer, 1980). The Warnock Committee argued that the care staff were vital to the family atmosphere of special boarding schools, reducing 'the institutional effects of boarding schools', and recommended a deputy head post for a trained child-care worker. Ann Shearer concludes that 'the whole elaborate structure of special education in boarding schools had developed with hardly any links with the system and philosophy of child care' (1980).

2.18 In establishments remote from the communities they serve, there is a growing unease about their *raison d'être*, when local units could provide the same specialist services and actively involve the families. Pugh and Russell (1977) give examples of



Boys at a Spastics Society coeducational grammar school doing their physical exercises.

Physically handicapped children working in an informal classroom at Craig-y-Parc School, a Spastics Society residential school in Wales.

'shared care' that are attempts at thorough inter-disciplinary co-operation, including joint funding, and are close to the communities they serve. A hospital-based unit, such as Honeylands in Exeter, is designed for day and short-term care only and includes a toy library. Parents can come to the unit freely and can be visited at home, and they can stay in the unit with their children until they feel happy about leaving them.

> Relief for parents is a major goal, and baby-sitting, overnight stays, weekend and holiday breaks are available on demand . . . no distinction is made as to the degree of mental retardation or physical disability, and parents of children with problems arising from social deprivation are also encouraged to use the services.
>
> (Pugh and Russell, 1977)

But will they, if the service is located in a hospital? Honeylands seems to be working well—parents do come and professionals do collaborate.

2.19 The question to ask of any professional teamwork is: do the clients benefit? Does it benefit a child to have an appointment for 'treatment' at a clinic only every three months or so? Does it benefit a family to travel miles for these appointments and be forced to accept professional decisions which they strongly oppose? Children and families do not often make the first approach to a professional team, and there is no guarantee that such a team can solve their problems any better than professionals working on their own. Frequently, the professional with the greatest experience of a problem is given the least weight in decision-making, for status relationships between professions are a strong influence on the dynamics of teamwork.

Professional power: assessment and identification

Reading Now read Sally Tomlinson's article, 'Professionals and ESN(M) education' (Reading 4.3), based on her study of children and professionals in Birmingham.

Comment It seems to Tomlinson that professionals spend most of their time discovering, assessing and treating children with special needs, and that they search for more and more clients, guaranteeing work for themselves: 'Professionals do not merely serve, they define the very wants they serve' (Hughes, 1971, quoted on p. 266). Tomlinson gives us concrete examples of how much at variance are the different professionals' perspectives on a group of children placed in a single educational category. The different accounts habitually given by head teachers, doctors or psychologists reveal that they think in different languages. No wonder teamwork is difficult: 'the development of extended "multi-professional" assessment, advocated by both the Court and the Warnock Reports, . . . assumes an unrealistic degree of communication, co-operation, and absence of professional conflicts and jealousies' (Reading 4.3).

2.20 The flow diagrams on pages 264 and 267 of the Reader show how lengthy a process assessment is, how numerous are the professionals involved, and how gruelling it can be for the child. The reorganization of local government in 1974 added further chaos by ensuring that none of the local authority services' boundaries coincided. Two things strike me at once about the assessment proposals: first, how would all this ever get done, when the numbers of children involved are projected by the Warnock Committee to be something like 20 per cent of the school population, and the relevant professionals are rushed off their feet already? Second, it looks as if a child might have to go through a series of assessment interviews, so that no professional writes an important report without having seen him. This would supposedly provide a system without loopholes, but designed to be flexible, to keep the procedure within the ordinary school as long as possible. But when you get to stage 5 and referral for special educational provision, the system tightens up suddenly and we are introduced to 'recording'—a formal register of children needing a lot of special help, a guarantee that provision is made—but it has the ring of the old 'certification' about it. In the Education Bill presented in the House of Commons in February 1981, 'records' are dropped in favour of 'statements', but the procedure is the same.

2.21 Chazan *et al.* (1980) quote the following comments made by special school heads, and by teachers in ordinary nursery classes which included handicapped children:

> Regular links with health visitors have been requested, but there has been no improvement.
> GPs need to liaise with schools.
> Social workers change too frequently in most cases to achieve continuity; their training is not appropriate.
> Advice is always welcome, but we've had very little as the agencies are fully stretched.
> I find from experience that other professionals are very reluctant to share their knowledge with the school.
> Social workers seem uninterested unless they are trying to place a child.
> They never seem to stay in the area long enough to see through or follow up these needy families.

Teachers do not want to be left in the dark, or to find that other workers are inaccessible but can still undermine them by taking decisions about their pupils without prior consultation. Chazan *et al.* concluded that outside support services were inadequate and that the teachers' expertise was often disregarded. Working together exposes the pecking-order that exists between, as well as within, professions.

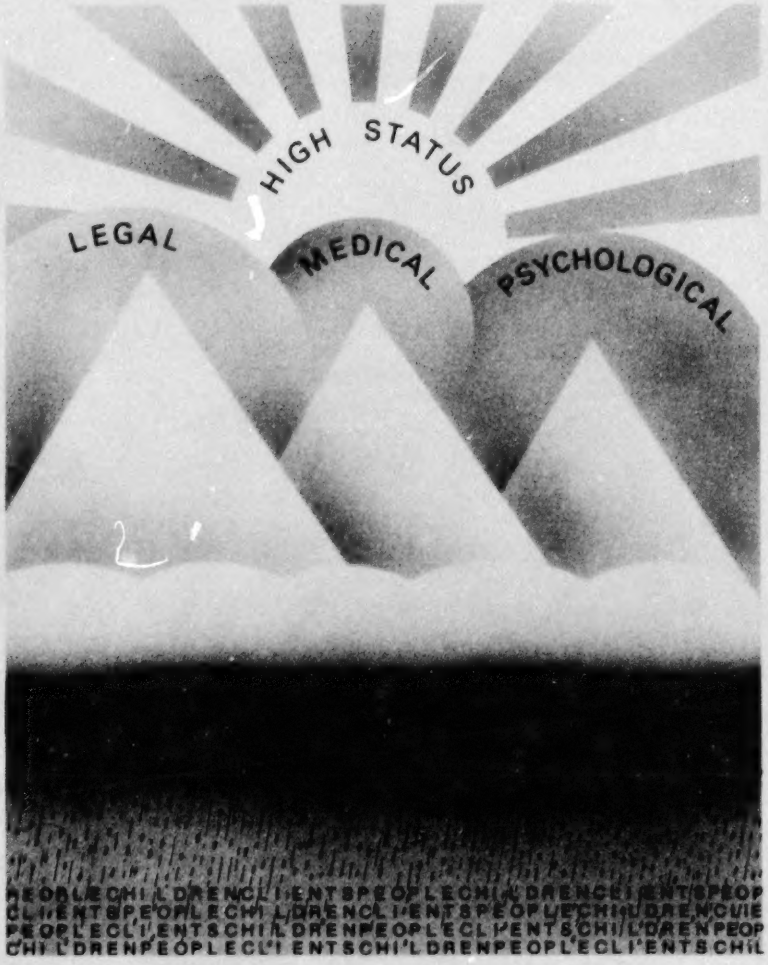
2.22 Which professions have a high status and which low? Look back at Table 1. How does the pattern of their involvement with special education relate to their prestige? Medical and psychological professionals commonly enjoy high status; doctors are not

A disabled person who wants to be an educational psychologist but was refused her teacher's certificate, despite favourable teaching practice reports.

necessarily closely involved with special education, but the status of their profession transfers with them. An inexperienced child psychiatrist writes more reports for other agencies of significance for children's lives than many experienced teachers. Within the medical profession, however, child psychiatrists have not been high in the pecking order. The authority to perform statutory duties does not give a social worker status; special education teachers have low status both inside and outside their profession. In a language unit, the following structure can develop:

> the teacher rapidly becomes senior, expressed in one unit as 'well I need to interview for the speech therapist post' along with 'I can't see why the speech therapist needs to interview for the teacher's post'. Generally, both are seen as junior to the EPs, who select children for the unit, and in some instances neither of them sits on review panels.
>
> (senior speech therapist)

Figure 1 lists some characteristics of high and low professional status. Do they agree with your experience?



Old-established
Academic background
Consultants
High pay Few Men
Competitive selection
Several jobs part-time
Independent of any one employer
Long training
Remote from clients
Special knowledge of theory and research
Specialist in one discipline
Treatment
Silent
Inaccessible
Headed notepaper
Advising
Teaching and lecturing
Contacts across the peaks of different professions
Non-unionized

Newly-established
Vocational
Administrative
Low pay Many Women
Easy to join
One full-time job
Dependent on one employer
Short training
In-service training
Close to clients
Special knowledge of clients
Broad range of skills and duties
Talk
Accessible
Scapegoats
Unionized

Client–professional relationships

2.23 Tomlinson makes it clear in her article that client–professional relationships can be more accurately described in terms of power rather than caring. Even if workers intend the relationship to be supportive, given that they can effect changes in the life of a child which may or may not be welcomed by the family, they are the ones with the power, especially when the client group is as disadvantaged as the West Indian families in Birmingham.

2.24 In his essay, 'Disabling professions', Illich (1977) argues that the dependence of 'clients' upon professionals is artificially created to serve a wider need: 'To be an active client of several professionals provides you with a well-defined place within the realm of service-consumers for the sake of whom our society functions. Under professional dominance the economy is organized for deviant majorities and their keepers'. Illich describes the growth of the 'caring' professions as 'therapeutic affluence', the practitioners as 'pedocrats' and ordinary people as 'paralysed in permanent intensive care'. 'Needs' are not objectively, immutably real.

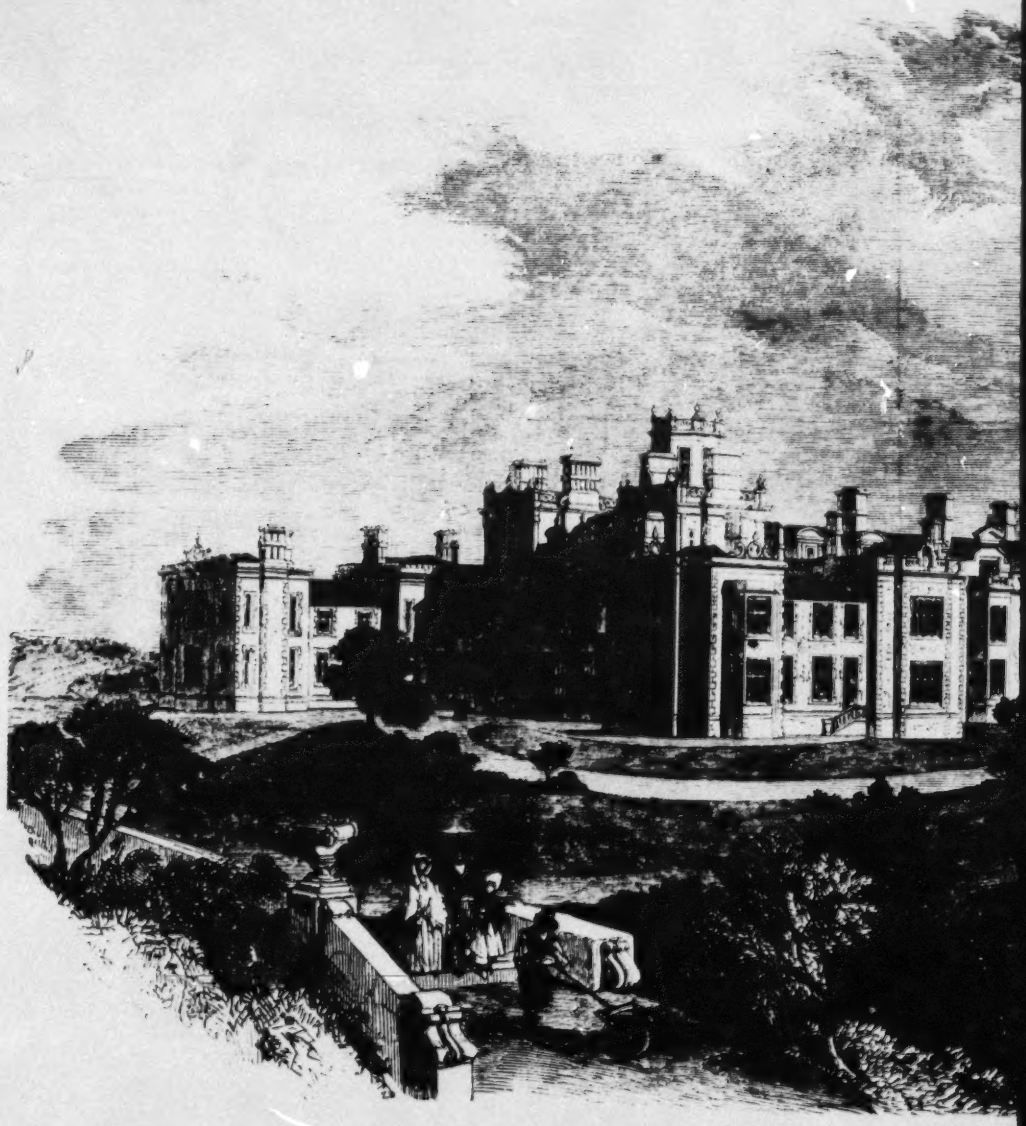
Parents are becoming more involved in the short-term residential care of their disabled children.

2.25 The Court Report reminds us that the Children's Act of 1948 laid upon local authorities the duty to care for children who had no family home:

> [but] whilst at first this 'care' was restricted to children separated from their families, it became increasingly clear that many children were deprived of the essentials for *proper* development in their own homes. The effects of both types of deprivation on the physical and emotional health of the child became a *recognized health problem* that children's officers and the health services together had to contain and prevent.
>
> (Reading 4.4; my italics)

This contains two important assumptions: first, that family life is the 'norm', and second, that some kinds of family life are better than others. These assumptions affect the definition of 'need' and may involve the professional in the following double-life:

> Imagine . . . the young teacher, affectionate adherent of the new musical sounds, blissfully happy in a well adjusted pre-marital sexual relationship, agnostic, currently reading *Couples* and *Portnoy's Complaint* and with rather an extravagant yen for jewellery. She may well find herself during a normal day's teaching, attempting to promote the appreciation of some classical musical item, defending the sanctity of marriage, attending a religious assembly, getting cross about the girls reading *risqué* illustrated stories and disciplining them for disobeying some over-zealous rule about skirt or hair lengths.
>
> (Midwinter, 1977)



THE NEW ASYLUM FOR IDIOTS, AT E

THE NEW ASYLUM FOR IDIOTS

THE occurrence, on Wednesday, of the Annual Festival of the supporters of this Institution, has suggested the accompanying Illustration of the grand object to which the exertions of the Society are at this moment directed—namely, the completion of the new Building at Redhill, the first stone of which was laid by his Royal Highness Prince Albert in June last. For this purpose, the Secretaries have just issued "A Special Appeal," wherein they state:—

The Board have already received 270 patients and pupils, and they have upwards of 200 now knocking at their doors, and craving admission.

They have declared their readiness to meet the urgent occasion, by providing an Hospital with 400 beds.

Still, the Board cannot look to complete this work of mercy with safety and prudence, except they can, during the erection, secure some £10,000 in addition to what they now have for the object.

They submit the matter in its own urgency and simplicity to a beneficent public, and earnestly entreat the needful assistance.

The New Asylum is now in course of erection, at Earlswood Common, Redhill near Reigate; half an hour distant from town; and is strongly commended by its salubrity, its convenience, and its capacities for the physical exercise of the inmates.

The building will accommodate 400 inmates, classified in the following manner—34 adult females; 66 adult males; 133 boys; 67 girls, 100 infants. Accommodation is also provided for the Governor, or Superintendent, Matron, Sub-Matron, Steward, Schoolmaster, and Mistress, and their assistants, and an appropriate number of nurses and domestic servants.

The main object in the design of the edifice (after considering the convenience of arrangement and classification) is to present to the eye of the unfortunate inmates nothing that is not calculated to produce an agreeable impression. The apartments will, therefore, throughout be finished in a neat and pleasing, but at the same time economic, style. Provision is, however, made for a few superior cases, or inmates, whose friends are willing to pay for the great advantages, in point of treatment, obtainable in an institution of this description. Some of these have private sitting-rooms, with accommodation for attendants.

The sitting-rooms and dormitories throughout are 13 feet in height; and the

RLSWOOD COMMON, REDHILL, SURREY.

allowance of fresh air to each person is believed to be very much greater than in any other charitable institution in England.

The building is approached by a noble flight of steps from an elevated terrace. The visitor, on entering, finds himself in a spacious hall, 30 by 21 ft, with waiting-rooms, attached. Proceeding directly thence, he passes through the principal staircase (in the central tower, 90 feet high), and, crossing one of the principal galleries, enters the children's dining-hall—a noble apartment, 60 feet by 35 feet, and 40 feet high, with an open timber roof. This room will be used for Divine service on Sundays. Immediately adjoining the dining-hall are the kitchen offices, which are also connected with the other wings of the building at back by light and airy covered ways, 16 feet wide and 520 feet long, in all—which, being formed principally of glass, will serve the purpose of conservatories and greenhouses. The principal recreation galleries are 340 feet long, 11 feet wide, and 13 feet high. From these open the dormitories and sitting-rooms. The board-room is a handsome apartment, 30 feet by 21 feet, having an open timber roof and panelled ceiling. The fittings of the principal apartments are of [illegible] of the rest of the building are of deal, stained and varnished.

There are ten staircases in the various departments of the establishment. The principal staircase, six feet wide, is formed of stone, from Hopton Wood, in Derbyshire—a splendid stone, perfectly white, almost equal to the finest marble; the other staircases, of a fine durable stone, from Wingeworth, in Derbyshire. The whole of the exterior is of stone, procured in the neighbourhood; the dressings are of Bath stone; and the windows are intended to be filled with plate-glass, which, being bedded in the stone itself, is considered more economical than glass of an inferior description with wood frames, while a much finer effect is produced.

The declivity in the ground on which the Asylum is being erected, has enabled the architect to introduce under one of the wings a basement, containing suitable workshops for tailors, shoemakers, basket-makers, carpenters, upholsterers, and other trades. The inmates of the Asylum are instructed in these trades, and have the advantage of every description of gardening, &c., as the estate of the charity consists of upwards of 120 acres. The building is supplied with bathrooms, plunge bath, and other conveniences; and everything necessary for the health and comfort of the unfortunates who may have to reside within its walls.

Confidentiality and accountability

2.26 Looking after both clients' interests and one's own professional interests can easily lead to double standards, which undermine credibility and authority with the clients and thus the ability to do the job of looking after them. Many professionals are only too aware of their clients' criticism, but not many would agree to show clients the records about them. Confidentiality can be a self-protective shield, taking off the pressure to develop a style of truth-telling that client, other professionals involved and worker can cope with. Information on assessment forms is rarely used by teachers. And there is a difference between respect for clients, which demands that their records are not casually publicized, and disrespect for clients, which dictates that even they shall not have access to their files. The trouble is that records often contain statements about the future, pessimism about a child's descent into delinquency, unemployment, a wheelchair or children's home. So, of course, they are not strictly records but speculations. This issue is debated at every level of bureaucratic life and the argument is that no professional is worth the name who cannot take full responsibility for his or her work, and that open files will avoid scapegoating and cover-ups. The ILEA document on leadership in child guidance units, however, has this to say about accountability:

> . . . responsibility for professional judgement and action lies with the professions concerned in their respective spheres, for in this they are autonomous . . . If the 'lead' member in a particular case is concerned about the part being played by a colleague he/she should bring the matter to the attention of the team co-ordinator, who may be able to resolve the difficulty in discussion with the senior team member in the profession concerned but they may, exceptionally, need to consult the appropriate member of the multi-disciplinary team at County Hall.
>
> (ILEA Medical Department, 1979)

2.27 What do you do with information given to you in trust by your clients, when its communication seems forbidden but which, if passed on to other workers, would increase the effectiveness of your problem-solving? Katrin Fitzherbert quotes some ludicrous examples:

> It has surely got out of hand when a letter from a child guidance clinic containing travel instructions is headed 'Confidential' because the printed stationery of the clinic automatically bears that heading; or when the psychologist's report with its printed 'Confidential' heading goes straight from the headmaster's desk into the filing cabinet and any useful contents it might have had for class or subject teachers is never exploited.
>
> (Fitzherbert, 1977)

2.28 People ask you to keep information 'confidential' when they *don't* trust you:

> I certainly would not discuss a patient's confidential affairs without his permission, but few ever refuse to give it. I do not ask social workers or others to take a referral from me until I have established a good enough relationship with my patient to ensure that he will agree to this plan.
>
> (consultant psychiatrist, quoted by Fitzherbert, 1977)

Summary

2.29 In this section, I have briefly looked at professional involvement with one child, at separate professional roles, at multi-professional teamwork in a variety of settings, at professional power and status-relationships, at relations with clients and current attitudes towards confidentiality and accountability. The system is labyrinthine and professionals numerous. So it is vital to ask whether or not they can actually help clients to solve their handicapping problems. In Section 1, I argued that there is an obvious sense in which they do not: the number of children referred to the professionals and the special education system is increasing. Greater sensitivity to individual special needs is thus an ambiguous characteristic of the caring professions, who look after more and more clients, stay very much in business, but are ineffective as regards prevention or thorough relief of problems. Indeed, their real clients may be the headteachers,

whose special schools they fill and whose ordinary schools they purge of problems. A late 1960s analysis of the work of educational psychologists 'showed a preponderance of individual clinical, diagnostic and therapeutic work with little indication of involvements in advisory, preventative or in-service training work' (Dessent, 1978). With a broad grouping which is primarily an administrative convenience, how could the range of social and educational handicaps be appropriately provided for?

> Illich has shown that the concept of a 'helping profession' is at least part myth. This is not to question the possibility of genuine altruism as a motive, but to raise the question of whether the helping professionals are not themselves mystified as to their role in the normative social order. Are they not, actually, agents of *social control?* 'Child guidance', after all, originated out of the intention to curb delinquency, and all forms of selection (e.g. for grammar schools or special schools) can be seen as ways of rationing scarce resources, without questioning why the resources are scarce . . . The psychologist's function should be that of client advocate . . . The 'expertise' involved is based solely on the psychologist's knowledge and/or experience of similar situations (as is that of the client) . . . This view repudiates much that is involved in the process of professionalization. It does not represent the psychologist as having a special and professionally private range of skills which are totally distinguishable from those of a school counsellor, a social worker or a community worker . . . It is reasonable to assume that social workers, counsellors, teachers and community workers, even doctors (not to mention those the professionals are accustomed to calling 'lay people'), also apply psychology to a greater or less extent . . . However . . . it is also right for a psychologist to be asked for specialist psychological knowledge. The least that should be said of a psychologist is that, if he does not have the appropriate psychological knowledge immediately to hand, he knows where to look.
>
> (Loxley, 1978)

3 *The growth of professions*

3.1 The growth of educational, psychological, social work, health and welfare professions depended upon a combination of three factors:

(a) social and economic conditions that created large-scale acute problems and the necessary helping personnel;

(b) an administrative–legal framework through which to work, for example the state elementary education system or the national network of county and borough councils;

(c) official documents which defined client groups, imposed duties upon local authorities and authorized specialized provisions for them, making financial resources available.

These added up to considerable investment in work with a variety of dependent clients, which grew as provision inevitably stimulated demand and gave the new professionals a job to do: identifying clients and making decisions about how to place them. Professional practices and jargon developed, so that spheres of influence were mapped out, and comfortable, profitable conditions of work were secured, protected by job-hierarchies and professional associations. Other professionals, administrators and head teachers became 'commissioning clients', adding more knots to the texture of professional life. The needs that the 'caring' professions were introduced to meet were those of the powers that be as much as, if not more than, those of the clients.

Historical background

3.2 When the first state provisions for children with special educational needs were established in the late nineteenth century, the academic-turned-applied-scientist, for whom training and research were prerequisites for professional practice, was still very uncommon.

3.3 Francis Galton established an 'anthropometric laboratory' at University College, London in 1885, where children could have their inherited abilities accurately assessed *for threepence a time! James Sully followed with the opening of the first psychology* laboratory in Britain in the early 1890s, 'to encourage teachers to study the individual child and seek advice on their more difficult problems'. Men such as Galton were interested in solving the problems created by the introduction of compulsory mass schooling in the 1870s for a combination of reasons. For example, they had patriotic fears about the large numbers of children who could not cope in the elementary schools, and were intoxicated with the new psychometrics—supposedly foolproof analyses of tests measuring intellectual capacities. In the university setting they became consulting experts to teachers, administrators, parents and politicians.

3.4 The best known professional of this kind was Cyril Burt, appointed by the London County Council in 1913 to be its first psychologist. His brief was 'the examination of children nominated for admission to schools for the mentally defective', and his referrals could come from magistrates, parents, school medical officers, teachers or care-committee workers (the forerunners of local authority social workers). These last two, as well as research students and other volunteers, helped Burt do what was supposed to be a part-time job. On the other hand, he was able to undertake major research projects and, in 1924, to become part-time professor of educational psychology at the London Day

The London Day Training College in 1907, five years after its foundation by the LCC Technical Education Board to provide teachers for the expanding secondary education sector; Sidney Webb was chairman of the Board.

Training College. It became the University of London Institute of Education in 1932, the same year that Burt became full-time professor of psychology at University College. His LCC appointment represented the first administrative separation of psychology from medicine, and a step towards the professionalization of applied educational psychology.

3.5 Compulsory, non-selective elementary schools were followed by the opening of state special classes and schools in the 1890s, but this was one institutional setting from which a new professional did not emerge. At the first London school to open a special class, the teachers had to be certificated for work in the ordinary schools and their appointments were temporary, so that they could recover from the strain. One inspector wrote of such a teacher: 'She is a somewhat extraordinary individual and who illustrates well that it is not safe to keep a woman at this class of work continuously' (quoted in Pritchard, 1963, p. 125). These teachers were paid more because it had been found that, rewards being equal, they preferred to stay in the elementary schools. It was also felt that teachers in special schools did not need professionalizing:

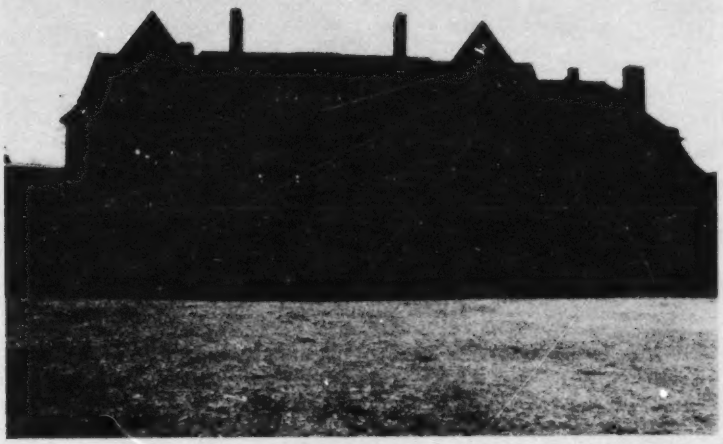
> The teachers have been attracted to this particular work by a strong sympathy with an afflicted class, and by a consciousness of a special faculty for helping that class. They have gained their success partly through experience, but mainly by means of enthusiasm and self-devotion. For work of this very exceptional character, these appear . . . to be the highest qualifications. Other training might add to them, but it could never be an efficient substitute . . .
>
> (Royal Commission, 1889)

Specific training for special schools was first introduced in Birmingham in 1915, for the teaching of the mentally deficient.

3.6 Outside, the high rate of infant mortality, and the malnutrition, susceptibility to disease and serious physical impairment of those children who survived, led to the establishment of the peripatetic professions of health visiting and school medicine. In 1867 the Manchester and Salford Ladies Sanitary Reform Association sponsored 'respectable working women' to go from house to house offering help and advice, and the first training and full-time appointments were established in Buckinghamshire in the 1890s. This preventive and educative work was, literally, of vital importance, and from it have evolved the modern community child welfare services. Medical inspection of older children in the schools began in the 1880s, and the first full-time school medical officer was appointed in 1890. But some criticized the service, saying that it was morally wrong to remove responsibility from the parents, and unnecessarily expensive when Poor Law Relief was still available. The Education Act of 1907 empowered LEAs to treat, as well as inspect, all children in the state schools, to safeguard their physical, mental and moral welfare. Where there were few GPs and hospitals, school clinics soon opened and the school medical departments controlled the assessment of children for the range of available educational provision. Since the Elementary Education (Defective and Epileptic Children) Act of 1899, doctors had been involved in the identification of mentally defective children. There were no psychological diagnostic tools yet in common use and doctors enjoyed far greater prestige than teachers, who did not then have much say in the testing and selection of children. The physical and mental examination of a child was a single procedure and, when teachers and doctors collaborated, it was the doctor whose decision was regarded as final by the board of education, largely on the recommendation of its chief medical officer (see also Unit 9, *Origins*).

3.7 The two world wars, though interrupting many existing professional services, stimulated the development of others, for example speech therapy, child guidance and social work. During the 1914–18 war, the neurologist Henry Head worked with brain-injured patients who suffered loss of speech. Voluntary, part-time and, therefore, usually female 'speech correctionists' or 'vocal therapists' were appointed in hospitals to help with this rehabilitation. In 1932 a speech therapist worked with defective children in local authority classes for the first time, on loan from the Central Association for Mental Welfare.

3.8 During the 1939–45 war, evacuation of children from vulnerable cities revealed the poverty and ill-health of many from the large cities, and the large number whose difficult behaviour made them unacceptable to their foster parents. The eventual housing in small hostels of these 'unbilletable' children added to a network of provision for



Craig-y-Parc, a residential secondary modern school opened in 1955 in a small country house.

difficult children, pioneered in the early thirties by George Lyward at Finchden Manor, Otto Shaw at Red Hill and David Wills at the Hawkspur Camp. Many became schools after the war. Influential figures included: Dr D. W. Winnicott, a psychiatrist who regarded delinquency 'as an illness of the individual' (quoted in Bridgeland, 1971); Susan Isaacs, psychoanalyst in orientation and head of the Department of Child Development at the Institute of Education in London (she collaborated with Cyril Burt in giving evidence to the 1931 Hadow Committee on Primary Schools on the intellectual development of children); and Anna Freud, whose 1942 *Young Children in Wartime* (quoted in Bridgeland, 1971) argued that the effects of maternal deprivation were worse than those of the blitz. It became common for therapeutic educators to aim for the restoration or imitation of a 'normal' family life, the disruption of which would prevent children reaching a stable maturity. But residential institutions are hardly a mirror of nuclear family life, nor are they likely to lessen maternal deprivation. What they explicitly offered, however, in contrast to other kinds of special provision, was a regime founded on love.

3.9 Professional identities gradually congealed and territorial claims were staked:

> . . . there is in the provinces a fairly widespread disinclination to utilize the psychiatric services which already exist . . . the main cause is a failure on the part of many general practitioners to appreciate the character of these services . . . an unawareness of the nature and prevalence of neurosis . . . a widespread mistrust of psychiatry . . . largely focussed on analytic procedures . . . [which are considered] a decadent and modern fad.
>
> (Blacker, 1946)

> Before the problem of coping with the disturbed child within a disintegrating and inadequate educational structure became a national concern, teachers were able to reject Freudian concepts as repulsive, alien, impracticable ideas promoted only by foreigners and 'cranks'.
>
> (Bridgeland, 1971)

> The new College [of Speech Therapists] made an early approach to the Association of Teachers of the Deaf with a view to union. The teachers of the deaf in Great Britain, however, preferred separate organization because of the disparity which they considered to exist between the academic standards of the two professions and because they felt that each already provided a sufficient area of specialization.
>
> (DES, 1972)

28

3.10 The setting-up of child guidance clinics in this country well illustrates the possible conflicts experienced by a multi-disciplinary team. The 1908 Children's Act established juvenile courts in Britain and magistrates requested psychological reports on the delinquents brought before them. The LCC supported the idea of a clinic that would see 'every type of mentally subnormal child, not merely delinquents' and Percy Nunn, principal of the London Day Training College, agreed with Burt that 'every child at some stage or other may need guidance . . . above all it must be realized that the work of such a "clinic" will be educational and social more frequently than medical or clinical' (quoted in Keir, 1952, p. 23).

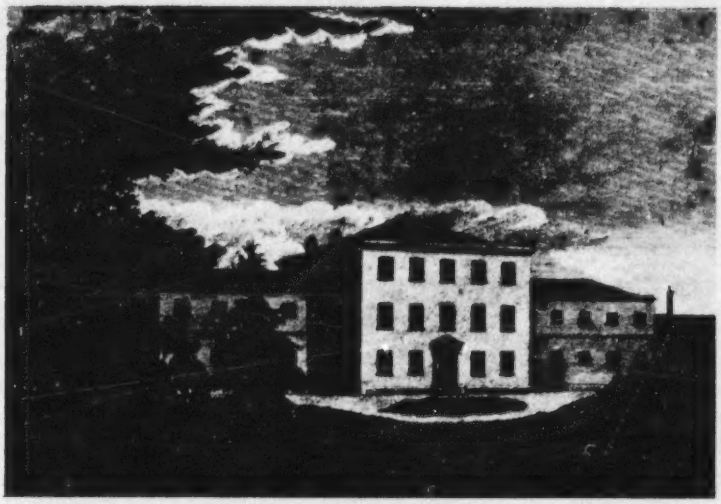
3.11 Burt was asked by the LCC to draft plans for the future organization of the school psychological service. The schemes he devised for delinquents were published in *The Young Delinquent* in 1925. Psychological assessments took precedence over medical and social reports and Burt envisaged clinics without psychiatrists. A London magistrate, Mrs St Loe Strachey, soon contacted Burt to say that she thought she could secure financial aid from the American Commonwealth Fund. She went to the US that year and on her return a meeting was held at the London Day Training College, at which it became clear that she supported the American model of child guidance, which was psychiatric in orientation.

3.12 Money for the first clinic in America came from a Chicago philanthropist, Mrs Dummer, in 1922. She was impressed by Dr William Healy's application of Freudian principles to the treatment of delinquents at his Juvenile Psychopathic Institute. The psychiatrist was the boss and the psychologist assisted with intelligence testing. The supremacy of concepts of mental illness was confirmed as more clinics were established by the National Committee for Mental Hygiene (founded in 1909). A group of British social workers visited these clinics after the London meeting, to receive some psychiatric training and relay back their recommendations. The Child Guidance Council was set up in 1927, with Burt as executive chairman, and the first clinic opened as the London Child Guidance Training Centre in 1928 with a psychiatrist, Dr William Moodie, as director. The post had been offered to Burt, but George Newman, chief medical officer of the Board of Education, had insisted that a doctor should be in charge if children were to attend during school hours; Burt also said he wanted more time for research. But he was unhappy about the arrangement:

> [Burt] completely rejected the view that psychology was concerned solely with the cognitive aspects of the mind: it was concerned, he insisted, with the whole mind. The proportion of cases in which pathological features were present was quite small, while social and environmental factors, with which psychiatrists were not specially trained to deal, were of preponderant importance. The lack of training of psychiatrists in normal psychology and statistical methodology ill-equipped them to direct child guidance establishments. Psychiatric diagnosis tended to be unreliable and the results of their treatment less successful than that of psychologists.
>
> (Hearnshaw, 1979, pp. 97–8)

3.13 This controversy is reflected in the division between local authority child guidance clinics, of which there were 20 in 1939, and hospital-based clinics, of which the first was opened in 1926 at the Tavistock Clinic (founded in 1920 as the Institute of Medical Psychology by Dr Crichton Miller). Child psychiatry had developed partly as a hospital-based branch of medicine and partly as a community service in clinics. The Maudsley Hospital was opened in South London in 1923, receiving both in- and out-patients, all of whom were voluntary. Psychiatry emerged as a specialization in the mid-nineteenth century when a number of influential asylum doctors—for example, Dr John Connolly, who ran the largest asylum in the country at Hanwell—abandoned physical restraint as the main, or sole, method of treatment. Instead, they adopted the techniques of 'moral management' which had been demonstrated by the Quaker, William Tuke, at his York Retreat. In the 1860s these doctors were sometimes called 'administrative psychiatrists' or 'psychological physicians', and were regarded as specialists, not because of any advanced training (of which there was none), but because of their practical experience.

3.14 In this section, I have looked at the kinds of events and crises that stimulated the development of the professions of health visiting, school medicine, speech therapy, psychology and psychotherapy and have tried to show that the crystallizing of professional



With his mentally ill residents at the Retreat in York in the early nineteenth century, William Tuke pioneered techniques far more humane and permissive than the customary corporal punishment and physical restraint.

roles led to the staking out of territory, battling for control of clients and sensitivity about relative status. Administrative absurdities can be the result of a personal quarrel; for example, the schools psychological services were separate from the child guidance clinics because of the animosity between Cyril Burt and William Moodie. Interdisciplinary work is not new and has always been difficult. I shall now look and see how training confirms historical precedent.

Activity 2 Here is an extract of a speech made by Cyril Burt on the subject of the professionalization of teachers:

> Just as doctors have themselves largely built up the science of medicine by their own recorded observations and experiments, so teachers are now setting to work to build up a science of education. At the moment it would be difficult to point out in this country any educational journal which plays the same part in the professional life of the teacher as the *Lancet*, the *British Medical Journal*, or the *Practitioner* in the life of the ordinary doctor. The articles published in the *British Journal of Educational Psychology* have always been largely the work of university research students working for higher degrees; but an increasing number of these are now actually teachers in our elementary or secondary schools . . . Medicine is regarded as a topic for experts, but education is not. No layman would write to *The Times* telling the doctor how to treat a patient suffering from bodily disease. But few laymen would hesitate to diagnose the mental state of a criminal they have never seen, to discuss the aims and methods of educating the normal pupils, or to lay down principles for the treatment of the dull and delinquent. The teacher has never enjoyed that sacrosanct reputation of being an expert and a specialist in his own particular sphere which the doctor has always claimed for himself . . . Nothing, I believe, would raise the professional status of the teacher so much as an attempt on the part of the teacher himself to turn his art into a science.
>
> (from an address to the London Head Teachers Association, 1938, quoted in Sutherland, 1980)

List the characteristics of the professional, as opposed to the layman, that Burt gives in his speech.

Now look back through the unit and make a second list of further possible characteristics.

In what respects do your two lists differ?

Does it appear that being a professional is compatible with caring?

Comment This view of professionalization is one that would increase the distance between expert and client and between expert and public opinion. Burt's speech reads like an invitation to mystify. The strength of this view lies in the potential value of published research, the literature of a new discipline; the weakness lies in the potential rigidity of an oversensitivity to lay criticism. Professional institutions can similarly function, either to preserve exclusivity and autonomy in the atmosphere of an élite club, urging the creation of valuable consultancies, or to maintain a high level of education and practice by means of training courses and official codes of professional ethics.

Make a third list—characteristics of professionals as you have experienced them. And a fourth—characteristics of your desired professional.

Perspectives on special education

3.15 Professional training and practical experience both influence a worker's perspective on special education. The psychological professions are closely involved with children in special education, and in educational and clinical psychology the emphasis is particularly on assessment. 'The particular contribution of psychologists in education services derives from their specialized study of psychological science and its application to education and to other aspects of human development. It should be the main criterion in determining their work' (DES, 1968). An EP may be influenced by what he knows of developmental, cognitive and social psychology, of psycholinguistics or of learning theory, but the way he sees the children will be moulded by the techniques he uses to plumb their educational difficulties.

3.16 Clinical psychologists commonly do their postgraduate training in a hospital, being paid by the NHS to study and to treat patients. Their approach contrasts with that of child psychotherapists, with whom they often work in child guidance clinics. Child psychotherapists also diagnose and treat the problems of an individual, and their professional training can also take place under the aegis of the NHS, for example at the Child Guidance Training Centre or the Tavistock Clinic, both in Hampstead. Using techniques derived from psychoanalytic theories, psychotherapists will look for an underlying cause or symbolic meaning of what visibly troubles a child, and will try to help the child to come to some understanding or 'insight'. Clinical psychologists more often aim to get rid of the obvious 'symptoms', using the much more structured techniques of behaviour modification. Both approaches are known to bring relief to some children, but both can be criticized for neglecting the social, institutional context in which the difficulty arose and in which the child has to live. (See Galloway and Goodwin, 1979, p. 118 for a further discussion of these techniques and a defence of behaviour modification; and Ryan, 1980, pp. 125–7 for a critique. See also Unit 12.)

3.17 A contrast also exists between the paramedical and social work professions, members of both of which are in close contact with children referred for special education. A speech therapist's three-year training leads to a diploma from the College of Speech Therapists, although four-year degree courses are becoming standard. Would-be therapists study subjects such as anatomy, neurology, linguistics and speech pathology and they often appear as white-coated clinicians. Psychiatric social workers, special social workers for the handicapped, and residential care workers will have different qualifications, but basic social work courses have a common core of sociology, family and group dynamics, theory and practice of social work. Courses cover:

> skills in the methods of intervention used by social workers to alleviate the problems of their clients and, where possible, prevent problems arising. Knowledge . . . of the social services, relevant legislation . . . Students also learn to be aware of their own personal feelings and prejudices when helping clients.
>
> (Central Council for Education and Training in Social Work, 1979)

Speech therapists receive 'patients' in an institution and 'treat' a huge range of vocal and comprehension disorders. Social workers tend to be out and about more, visiting families at home and accompanying children to a school, court or other office. Although

a therapist is concerned with communication in the widest sense and may be convinced that language disorders, even when corrected, leave in their wake a permanent and pervasive social handicap, the professional structure has encouraged them to see clients' problems within a fragmenting model of diagnosis and treatment. Social workers are often criticized for becoming too enmeshed in the lives of their clients, allowing their own needs to burden the families instead of the other way round, and for an informality which affronts administrators and the members of other professions, but they do have some experience of handicapping problems. Health visitors' training resembles that of paramedicals, being general nursing, but their job is much more like that of a social worker.

3.18 The brief of an education welfare officer (EWO) is succinct—to deal mainly with the problems of school attendance. In 1972, a report of the Local Government Training Board recommended that EWOs start with a social work qualification because their role should not be regarded simply as an administrative chore, but supportive and advisory, forging a link between home and school. The bulk of their work is with teenage truants. Paediatricians, on the other hand, see young children with physical, sensory and mental handicaps, as well as those with alleged, but invisible, neurological faults. From a hospital base, they can be more remote from professionals working with the families than in a group practice or health centre, where there is likely to be greater involvement with the clients and their families. Paediatricians sometimes become child psychiatrists or clinical medical officers with the area health authorities' community health service. (See Unit 11, *Biology and handicap*.)

3.19 Health visitors, residential care staff and elementary school teachers were originally appointed to do a job that needed doing. Only later were professional associations, training colleges and recognized examining bodies established to decide: (a) what such workers should know in order to do that job, (b) how to attract further recruits and, (c), how to protect the newly-trained. No one kind of knowledge was the sole requirement.

3.20 Here is a summary of training options:

Professional groups:
psychological, therapeutic, educational, social, medical, nursing, legal.

Places of training:
university, polytechnic, private college, college of education, voluntary society, hospital, local authority, teachers' centre, college of further and higher education.

Organizing bodies:
government departments, universities, hospital boards, professional associations, voluntary societies, private institutions, semi-independent training councils.

3.21 The numerous possible training patterns cannot simply be sorted into vocational and academic. But whatever choice is made will constitute the root of later working attitudes and professional status.

3.22 Professional roles, the content of professional training, specific ways of working, official handicap categories and provisions, and the individual worker, blend to produce a perspective that can be crude, narrow, vague, subtle, ambivalent, rigid, imaginative or superficial. Table 3 gives a sample list of resulting professional practices.

3.23 A psychiatric social worker may see her role as mainly therapeutic and perhaps also preventive, and may be more sympathetic to the children referred to her (at a child guidance clinic or school) than to the referrer. These children will quite often be described as 'hyperactive' or 'disruptive', for whom, officially, there is no special help. (See Unit 11 for a discussion of the unofficial categories.) A health visitor envisages doing preventive and educational work but may find that administration gets in the way. An EP's role, however, seems to be mainly administrative, despite the intended therapeutic and educational parts.

3.24 Each profession is likely to see its members as having a characterizing role in relation to their own client groups. But professionals do not only work with referred children, and they may have to play a different role depending on the audience—for example, colleagues, the local authority, parents.

Table 3 Professional practices.

Professional roles	What professionals do	Which children do they officially see (the two per cent)?
Preventive	advise	delicate
Therapeutic	teach	ESN
Educational	treat	epileptic
Administrative	nurse	maladjusted
Managerial	professionally train	blind
	consult	partially sighted
	confer	deaf
	write letters	partially hearing
	decide	physically handicapped
	refer	speech defective
	organize	
	cure	*Unofficial categories*
	control	(many professionals see a far
	assess	wider range than the two per
	diagnose	cent—more like Warnock's 20
	prescribe	per cent)
	write reports	autistic
	telephone	hyperactive
		disruptive
		dyslexic

Activity 3 Take the professional with whose work you are most familiar. Then, using the columns of Table 3, list what you believe to be relevant to this worker. If you have experience of several of the professionals, copy out Table 3 and write the names of your chosen professionals down the edge, drawing arrows to their practices, categories of children seen and professional 'role'. You could add what you know of their other client groups, or anything you feel I have omitted from the table.

3.25 If the style and content of training are integral parts of a professional's working persona, then anything that would dissolve existing arrangements, however laudable in itself, represents a threat to professional identities and relative status. Two current issues are set fair to make just such an attack: first, whether or not professional education should be generic or specialized and, second, whether or not professional boundaries should be crossed. Both stem from a move to make services more responsive to genuine needs—a move which most professionals publicly support.

Generic or specialized training?

3.26 The 'generic' training course advocated by the Seebohm Report on local authority and allied personal social services (DHSS, 1968) is a broad introduction to the knowledge required by a social case worker, and is designed to be taken by students whose subsequent job experience will vary considerably. It simplifies the organization of training for a hybrid profession and is potentially flexible, preparing workers for changing roles. The Certificate in Social Work is planned by CCETSW to be a generic course for those who will later work with groups of handicapped children and adults. In 1959, the Younghusband Report on local authority social workers envisaged a course for health visitors, social workers, occupational therapists and residential care staff (para. 889). One EP 'sees no reason why you cannot have a generic kind of psychologist . . . Many of the skills involved in dealing with people at different age levels and stages of development are similar' (Loxley, 1978; see also the Court Report—Reading 4.4).

3.27 Any professional whose clients (though perhaps nominally a homogeneous group) present a wide range of problems will perform an essentially generic role, despite years of specialist training. Critics of the generic approach argue that it leads to superficial,

naive practice. In his introduction to a series of transcribed interviews with the parents of handicapped children, Dr Mervyn Fox writes:

> There is no doubt that many of these families present extreme technical problems for the generic social worker, who is faced with demands for practical developmental advice, information on environmental resources of a highly specialized nature, and interpretation of the actions of the half-dozen other professionals involved as well as the need for utilizing knowledge of the unconscious implications of overt behaviour and general emotional factors . . . my personal prescription is unavowedly one of a return to specialization . . . This is not to decry the value of a generic training, but only to emphasize what I see as the impossibility of generic practice.
>
> (Fox, 1975)

And one of the psychologists who took part in the discussion transcribed in Case study 26 said: 'In order to become reasonably proficient in any sphere you have to specialize. A counsellor, psychotherapist or social worker can give support to the family. I'd find that very difficult.' But there's no reason why a professional should work in isolation; in their book on the education of slow learning and maladjusted children, Galloway and Goodwin suggest that 'there is a world of difference between a generic social worker and a generic *team* containing specialists in different fields' (1979).

3.28 It may be that there is a need for different kinds of knowledge at a level of sophistication and detail to be called 'specialized', and it may be that one person does not have the time to develop this in more than one field, so that it would be a waste not to utilize a specialist's experience. But specialization does perpetuate a fragmented view of clients and their problems, protects the remote peaks of professional hierarchies and reduces flexibility and commitment to change.

3.29 Broad professional training is not a novel idea, however:

> A training course . . . for work in either the educational or the health services would widen the field of opportunity and so make the career of a psychologist more attractive . . . The difference in the work of the two services need be no obstacle to the provision of a common training . . . Towards the end of courses a certain amount of specialization, mainly in the practical work undertaken, could be introduced.
>
> (Ministry of Education, 1955)

3.30 Nottingham and Stirling Universities run graduate courses in child psychology designed to lead to work in the health, education or social services:

> The training of all psychologists working with children needs to include an understanding of normal development, of family dynamics and of group interaction, of pre-school problems, of learning disabilities, of counselling techniques, of school influences, and of parental psychiatric disorder, as well as the more traditional psychological methods of assessment and treatment.
>
> (DHSS/DES, 1976, 15.18)

3.31 The Jay Report recommended that community care staff should attend courses run by the CCETSW, but this has caused a storm of protest from the nursing councils. The committee argued that CCETSW's Certificate in Social Work 'offers a modular design which fits in well with our model of a two-part general (i.e. residential care) and specialist (i.e. mental handicap) course'. And they gave the following reasons for not creating a new profession without any links with other workers: its status would be low and recruitment poor, its client group would be even more isolated and professional mobility would be lost (DHSS, 1979, p. 107). Thus professionals seem to find it easier to change their practices than the organization of their training, confirming that their identity does not depend on what they find themselves doing.

Training and work

3.32 How many professionals find that their training turns out to be inadequate, irrelevant to the job they actually do? A professional identity and ideas about a practical role evolve during training—the acquisition of 'expertise'. Knowledge, skills and a

perspective on the problems to which they will be applied are the justification for calling yourself a social worker, psychologist, teacher, therapist. You may want to cure illness, to relieve anxiety, to facilitate independence, to teach literacy, to prevent birth injuries, to find appropriate schools for 'anti-social' children or to promote wider acceptance of handicapped and difficult children. But you may not achieve any of these things. Not just because your particular sphere of influence has been polluted by other workers, but because these aims may, themselves, be neither possible nor desirable in practice. And the human inside the professional may get in the way.

Reading Now read the case study, 'Off duty: educational psychologists discuss their job' (Case study 26).

Comment Training could be a waste of time, both if the course contained too little or too much in it. The value of practical work before and during training was stressed. Why do training courses omit to mention secondary schools when secondary schools refer so many children to EPs?

How can professional training prepare novices for loyalties divided between client and employer, to both of whom they will inevitably be committed, though in different ways? Does it leave you more free to care when your clients are not paying your salary? Could the fact that many professionals experience this division of loyalties indicate that their employers do not have the clients' interest at heart?

The psychologists were particularly concerned about two practices, IQ testing and seeing children in one-off, hourly sessions. Tests were criticized for being unjust, inappropriate, artificial, deceptive; they were defended on the grounds that they provided a structure for understanding a child's behaviour and thinking strategies. Hourly sessions were criticized because decisions affecting a child's entire educational career could be made on the basis of one interview, and it was acknowledged that, in any kind of meeting with a child, explaining to them why you were there—'coming in as an educational psychologist for intervention, plonk'—was difficult. One of the psychologists argued that it was not always the referred child who should be the client, and that the importance of administrative and consulting work should not be forgotten. Also, problems of communicating with children depended not only on the approach of the psychologist but on the kind of child—what do you do with deaf children, for example? Perhaps you do away with assessment interviews altogether.

3.33 Professional training is more concerned with the various handicapping situations than with criticizing a system that finds them so, but there may be a reason for this:

> The increased emphasis on the academic content of social work education has been accompanied both by a greater stress on the more theoretical studies in the social sciences and by greater uncertainty about the objectives and content of practice teaching in the field. The latter has been due partly to the rapid turnover of practice teachers and partly to uncertainties about overall social work objectives following two stages of reorganization in local government personal social services, and the undifferentiated expectations and demands imposed on Parliament and the general public.
>
> (CCETSW, 1976)

3.34 The same document says that worries about the effectiveness of social work training are the result of 'the apparent increase in violent behaviour in families and in communities'. This looks like an appeal for services to be geared to real problems but it also indicates that the role of a social worker is partly custodial. This is not surprising, for practising professionals soon find that clients, employers and popular opinion all want them to do something different, and that these often incompatible expectations nevertheless influence what they do.

3.35 Cyril Burt advised against having clear expectations. In 1914 he wrote to the LCC's chief inspector:

> Educational Psychology is not merely a branch of applied psychology . . . the educational investigator cannot merely carry over the conclusions of academic psychology into the classroom. He has to work out almost every problem afresh,

> profiting by, but not simply relying on his previous psychological training. He has to make short cuts to practical conclusions, which for the time being, leave theory or pure science far behind.
>
> (quoted in Sutherland, 1980)

Overprofessionalization

3.36 If the content of the training of professions with different names becomes increasingly similar, and the members of the professions develop similar therapeutic skills in practice, will territorial claims be illegitimate? Could anyone do the job? Or, if a physician takes on clients for family therapy, or a psychiatric social worker assesses the reading age of a child, or a special school teacher undertakes to find jobs for her school leavers (or tries to resolve the underlying conflicts that erupt into violence in the classroom), does this not amount to overprofessionalization—going beyond what you can know from professional training or work experience, and unjustifiably extending your influence? Professionals involved in special education are inclined to be imperial in this way, particularly because they see children whose difficulties swamp their whole lives.

3.37 The desire to deal with the 'whole case' can lead professionals into building empires that their training and experience do not justify. For example, a remedial teacher in a child guidance clinic may want to do all the home visiting, counselling and assessing in connection with her pupils. She may be convinced that if she does not, then social workers and psychologists will probably keep her in ignorance of what they are up to. An EP may reject formal psychometric testing and conduct family therapy sessions in a school, which he sees as appropriate, both in terms of setting and technique; but where does this leave the psychiatric social workers assigned to that school and belonging to the psychologist's own clinic team? Most professionals involved in special education develop informal therapeutic and evaluating skills and, quite rightly, use them. But when does this constitute 'overprofessionalization'? When one profession strikes out in isolation from the rest, seeking a monopoly over certain groups of children, becoming more resistant to and lazy about changes in its attempts to preserve status, this is also overprofessionalization. Clients themselves may encourage this because they would rather turn for help to the same person, whom they know and like, whom they use as if she was a one-person team anyway, and who would simplify a confusing, pressurizing world of compartmentalized services.

3.38 Overprofessionalization may be the result of exasperation at the inefficiency or different approaches of other workers, and a confidence that, if you do it all yourself, the problem will actually get solved. But it may also be the result of insecurity. For example, one of the psychologists in Case study 26, having positively advertised the wide range of his duties and justified the use of structured techniques, finally admits that he does not believe that psychologists have much impact on the lives of the children they see. 'Identification as a professional is a way of redefining failure as success' (Loxley, quoted by Dessent, 1978).

3.39 In this section, I have indicated that the commitment of those who work with children in special education is always tempered by the demands of colleagues, employers, public opinion and other professionals. The kind of training undergone by different professionals leaves a permanent legacy of high or low status, whether or not its content turns out to be relevant to the job that needs to be done. So many workers experience a mismatch between training and work that a major overhaul of existing arrangements is called for.

4 *New professionals for old*

4.1 Suggestions about new kinds of caring professional in a more integrated system of education have crystallized around four sorts of worker: peripatetic specialists, advisory support-services workers, community-based care workers, and laypeople (including parents).

4.2 Peripatetic specialists, although perhaps spending valuable time travelling, can work in any school where their services are required. In 1974, South Clwyd integrated physically handicapped children into ordinary schools and, as a result of the report of a research physiotherapist, a peripatetic service was set up. This provided for 110 children, mainly with spina bifida and cerebral palsy, who attended 33 ordinary schools. 'Professionally one would, ideally, like to treat each child' (Davies, 1979), but this is not possible and the nursery assistants carry out the programmes, which are designed for maximum independence, not protection. The physiotherapists also supervise the training of teachers and assistants and have regular professional group meetings. School doctors still have to give written assent to any aids ordered by the therapists, which have to come from health authority funds. Parents have been included in the scheme and encouraged to help with exercises at home. Jean Davies describes the service as one supporting 'sensible integration', relying on advisers and special schools for additional help, and believes that the in-service training of staff beforehand is vital for integration to be successful. But this, she believes, 'would be a most rewarding experience for a teacher'. TV programme 4 looks at the work of physiotherapists in an integrated paediatric service that includes speech and occupational therapists, and that parents and teachers find more accessible.

4.3 The support-services worker is increasingly important in the drive towards greater integration, whether in the schools psychological service, the education welfare service, the careers service or the school health services:

> If the same people covered both the special school or units and the schools which send children to them, they should be able to encourage communication between special and ordinary schools, using the resources of each to meet the needs of individual children before their problems become acute.
>
> (Galloway and Goodwin, 1979)

These authors argue that support services have the strengths of traditional child guidance clinic teams, but without their isolation.

4.4 If there were more small, locally-funded homes for children with severe impairments, then such children could participate more fully in the education, welfare and social services provided in the community. A new breed of community-care worker, not tainted by hospital practice, is badly needed. The Jay Report on mental handicap and nursing care (DHSS, 1979) outlines a model based on the following principles: 'living like others in the community', 'individuality' and the right of access to whatever ordinary and special services are needed. Mentally handicapped children should be removed from hospitals, not automatically categorized as 'sick' children, and should live in small residential units close to their parental homes, preferably on a short-stay, crisis intervention or baby-sitting basis so that they could remain with their families as much as possible.

4.5 When it comes to children, parents *are* the professionals. Theirs is the commitment and the knowledge. But paid workers can provide the support, teaching, treatment, advice, aids and concrete help that families cannot supply for themselves. Here is one view of the way in which client–professional relationships should change:

> The ideal is the absorption of professional into laity, the melting of institutionalism into the popular culture and the disestablishment of the great public welfare churches . . . the criterion for the public service professionals may of necessity become their ability to find this human scale and human face for their efforts . . .
>
> (Midwinter, 1977)

4.6 Geoffrey Bookbinder, an EP, argues that the Warnock Report paid far too little attention to the rights of parents to make decisions about the educational careers of their children, and that the psychological assessments

> may indicate that a child is weak in language or numeracy skills or that s/he has poor eye–hand co-ordination but they are not designed to show the things that really matter to the child and family, i.e. their basic views and attitudes to life in the context of which his/her real educational needs must reside.
>
> (Bookbinder, 1981)

The widespread medical model of diagnosis and treatment is illegitimate, Bookbinder argues, because 'we cannot prescribe the most effective way to teach a child without reference to the precise conditions prevailing in the teaching situation and the many variations that the teacher–child relationship may take'. Not enabling parents to make an informed choice from available options reveals the patronizing paternalism of professionals in special education, and a lack of respect for parental hostility to the stigma of segregated provisions. Multi-disciplinary assessment procedures are particularly hard for a parent to contest.

4.7 In the past, of course, it was lay volunteers who played this role of philanthropic patron, and the advocacy of more volunteer schemes today is complicated by the question of whether the old social imbalance would only be perpetuated. In July 1981 *The Times Educational Supplement* carried a report (Ball, 1981) of the Community Service Volunteers' School Concern Project in Salford, which involved children from ordinary schools making aids for particular children and adults in special provision. This has increased the social contact with, and understanding of, the disabled in the area, but does not mean that the disabled play a greater part in the life of the ordinary schools.

4.8 Andrew Sutton, author of Unit 8 (*The powers that be*), has criticized elsewhere (1978) the present psychological services: 'They don't provide a service—they're generating undoable work and this is no "service". On the whole it's a service for teachers, a complaints service.' His view of change, however, is in the direction of a more dominating professional than the one proposed by Midwinter.

> I can't see any point in being involved in special education unless you help run it and say which children go where, what the schools should do and what the pattern of provision should be . . . We should be looking for the new things and telling people that the thing we told them five years ago is now out of date . . . I'm thinking about psychologists working to find out new things and trying them out, not just dealing with problems as they arise.
>
> (Sutton, quoted by Dessent, 1978)

4.9 John Quicke (1980) canvassed about 300 psychologists and dubbed them the 'cautious experts', reluctant to use specialized knowledge and lazy about reading books and journals. He argues that the profession of educational psychology should be 'clearly opposed to the notion of a helping profession which took upon itself the burden of responsibility for the system's problems'. He reminds us that medicine is the classic helping profession, but he is convinced that a medical model is inappropriate for the work of an EP, who should try to reduce the distance between himself and the children, and to share the problem-solving with their teachers. Caring consists in the promotion of democratic education, which could be realized in 'alternative schools', voluntary for all comers. Solidarity should not be sought with a mysterious professional élite but with a cross-section of professionals, clients, parents and the public. Combined with in-service training, this could lead to a genuine integration of personnel and disciplines, thus abolishing the separation between training and work.

4.10 Bill Gillham argues that professionals will have to work with families as colleagues rather than consultants,

> an attitude which recognizes the primary importance of those adults who have most to do with a child, and the primary effectiveness of altering what happens *between* an adult and a child—be it changes in teaching method, handling or attitude—to achieve changes for the child.
>
> (Gillham, 1978)

4.11 More professionals need to be trained like apprentices, following in-service courses combining practical and academic work and providing the personal experience which otherwise can come as such a shock, especially as qualified professionals often know less about the problem than the client. This would guarantee sustained contact with the world of the clients but would, of course, shatter preconceived ideas about professional roles and strip many professionals of their high-status birthright.

4.12 High status does not necessarily mean autonomy, however, as the actions of professionals are constrained by the expectations of other workers. The head of an emptying special school or the head of an ill-resourced ordinary school may expect the psychologist as the main statutory referring agent to pass problem children on to the segregated provisions. If the psychologist believes that it would be in the best interests of the children for them to stay in the ordinary school, then, if this is forced on an unwilling head, the recommendation will be doomed, because the head has a stake in its failure. At the moment, a psychologist is not a free agent: 'If educational psychologists are to have an independent advisory function they should not be implicated in formalized assessment procedures' (Loxley, 1978).

4.13 The possibility of change is limited by historical precedents and current professional hierarchies, both of which embody a commitment to the status quo. The Jay plan quoted above in paragraph 4.4 has been criticized for being too expensive, for cutting across departmental budgets, for requiring a new breed of staff—the control of whose training is a bone of contention—and for denying the positive qualities of subnormality hospitals.

5 *Conclusion*

5.1 Professional practices depend upon tradition, professional organization and the status of training. Professions often preserve obsolete institutions at the expense of helping a changing clientele with new difficulties. They can do this because so much of their work is hidden from clients and accountability rests within the profession or with its employers, who protect their workers from the slings and arrows of outraged clients.

5.2 Poor Law Guardians opposed the 1909 Royal Commission Report which advocated their abolition. The members of School Boards opposed the 1902 Education Act for the same reason. Balfour, however, wanted 'to reach a strata of experts not now accessible' and argued that 'no *ad hoc* authority now can cover the whole ground of education' (1902). Self-preservation is obviously a strong conservative force.

5.3 The development of more democratic inter-professional work is constantly being sabotaged by the chaos of the various services' administrative boundaries, so that inter-disciplinary work is halted because no-one knows who to pay for what, who should give permission for what and what would happen if . . . they had the nerve to set new precedents. Also, the present government is still committed to preserving hierarchies and the Minister for Health and Social Security has, at the time of writing, just announced the creation of more consultancies. Cuts in public expenditure have drained the energies of the welfare services (see Sally Tomlinson's Reading 4.3).

5.4 Deprofessionalization, then, implies a radical change in the administrative and financial organization of the education, health and social services, as well as a thorough overhaul of professional training and practice. It implies a devolution, so that stigmatizing segregated institutions become redundant, and client–professional relations more balanced and flexible.

> There are, it is true, a considerable number of matters where practical action is delayed by the absence of sufficient knowledge. There are more perhaps where our knowledge is sufficient to occupy us for the next 20 years, and where the continuance of social evils is not due to the fact that we do not know what is

right, but to the fact that we prefer to continue doing what is wrong. Those who have the power to remove them have not the will, and those who have the will have not, as yet, the power.

(Tawney, 1913; quoted by Rose, 1972)

5.5 Think of each profession involved in special education at the moment as an individual country, with separate citizen-groups, but belonging to a single continent whose international borders are disputed, invaded, obliterated, recreated. Diplomacy is shaped by the status and motives of the different countries, and what one country does will influence at least some of its neighbours on the continent. Status depends upon age, stability, territory, population, wealth, institutions and propaganda. A country is motivated to legitimize its government and extend its way of life, to become prosperous. International relations are the juggling of spheres of influence, with harmony or hostility, isolation or interference, and are as important to participating countries as domestic affairs. All these things are natural, not because they are scientifically necessary, but because they spring from the wish to survive. And all of these things are true of professions. Using this metaphor may help you to understand what professionals do and why, and how difficult it is for client-citizens to bring about radical change.

Activity 4 (a) Professional roles may be described as preventive, managerial, educational and therapeutic. Go through the unit and list those whose work typifies each of these roles.

(b) In the introductory section, I listed the three main questions of this unit. Taking each in turn, after the fashion of the activities in Unit 5/6, make notes in answer to these key questions.

This activity should help you to summarize the unit and to collect your own thoughts together as a basis for further discussion.

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Unit 1/2 Special biographies	Unit 10 National perspectives
Unit 3 Family views	Unit 11 Biology and handicap
Unit 4 Education for adult life?	Unit 12 Psychology and special education
Unit 5/6 A special curriculum?	Unit 13 Handicap is social
Unit 7 The professionals	Unit 14 Eradicating handicap
Unit 8 The powers that be	Unit 15 Research in special education
Unit 9 Origins	Unit 16 An alternative system: a special imagination

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For this course, she has also written Units 9 and 11, and is a co-author of Unit 16.

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